Printed: 12/23/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/AND PLAN OF CORRECTION IDENTIFICATION NUMBER		JLIA '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E577		B. WING		12/23	3/2014
ANDERSON COUNTY HOSPITAL LTCU			421 S M	APLE ST-PO	BOX 309	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3		F 000			
	The following citation Health Resurvey.	ns represent the findings	s of a				
	483.10(i)(1) RIGHT SEND/RECEIVE UN			F 170			
	The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on interviews, the facility failed to deliver mail to the residents on Saturdays.						
			S.				
	Findings included:						
	- On 12-17-14 at 8:3 mail is not delivered	37 a.m., resident #2 stat on Saturdays.	ed,				
	On 12-17-14 at 1:03 p.m., resident #22, stated that he/she would want to receive mail on Saturdays. On 12-17-14 at 1:07 p.m., resident #28, stated he/she would want to get mail on Saturdays if he/she had any. On 12-17-14 at 1:11 p.m., resident #1, stated he/she would like to get mail on Saturdays if it still came on the other days of the week.		ed				
		a.m., social services state is open on Saturdays, on Saturdays to the	I .				
		a.m., administrative sta					
LABORATOR'	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(X6) DATE

(X2) MULTIPLE CONSTRUCTION

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SU COMPLET		
		17E577		B. WING		12/2	23/2014	
	OVIDER OR SUPPLIER ON COUNTY HOSPIT	AL LTCU	421 S N	RESS, CITY, STA IAPLE ST-PO ETT, KS 660	O BOX 309	N of coppration (Y		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	stated, the mail is piby the engineering of hospital. It is delivered by staff. It Saturdays, even tho until noon. On 12-17-14 at 10:1 stated, the post officis picked up two time Friday. Resident may one time a day. May by volunteers or staff. The facility lacked at to the residents. The facility failed to the residents of the 483.15(f)(1) ACTIVI INTERESTS/NEED. The facility must proof activities designed the comprehensive at the staff.	icked up from the post of department and brought red to the nursing facility t is not delivered on ough the post office is opout 10 a.m., administrative stope box is at the post office as a day, Monday through ail comes to long term call is delivered to the resident. In policy regarding mail defective mail on Saturday facility. TIES MEET SOF EACH RES Dovide for an ongoing proof to meet, in accordance assessment, the interest land psychosocial well-light.	to the rand en aff L e and gh are dents elivery s to gram e with is and	F 170				
	The facility reported with 15 selected for observation, intervie facility failed to prov	ew and record review, the ide individualized activiti residents reviewed for	s, e					
	Findings included:							
	- Review of residen	t #26 physician orders, o	dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
				IAPLE ST-PO TT, KS 660				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 248	11/4/15, documented 7/11/13, with the follow Syndrome (chromoso characterized by vary retardation and multip dementia (progressive characterized by failin behavior disorder. The annual MDS (min 7/9/14, revealed the rivision, and wore correwith short/long term in severely impaired decinterview for activity president determined if to music he/she liked as pets, do things with residents favorite actifresh air when the we participate in religious was not important to land magazines to reanews. The resident reassistance for walking staff assistance for walking staff assistance for trafor mobility. The CAA (care area as for cognition documents)	the resident admitted or ing diagnoses: Down's imal abnormality ing degrees of mental ple defect), blindness, as mental disorder ing memory, confusion) inimum data set), dated esident had highly important had be included in making. The residual references revealed that was very important to be around animals, such groups of people, do vities, go outside to get	with aired dent e listen uch the t and rs, e ed lchair	F 248				
	ability to recall some of Dementia is associated later years of life, and continued decline. The the resident is legally can see outlines and	ed with Down's syndror can expect to see a e CAA for vision reveal blind, however the resi shapes, but not much e cluded the resident req	ne in led ident else.					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
AND I LAN O	CONNECTION	IDENTIFICATION NUMBE	IX.	A. BOILDING		COMILE		
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO				
				TT, KS 660			0/5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 248	Continued From pag	e 3		F 248				
	The CAA for Activities did not trigger. The quarterly MDS, dated 10/9/14, revealed no changes from the prior MDS.							
	impaired memory to p for the resident to allow The care plan lacked this resident with special blindness and Down's Review of the initial and 7/9/13, documented to interest was music, we older cartoons and old resident was kind of a to be an Elvis fan, moderated to be an Elvi		ed ity ys he sed rrent sion.					
	Review of the quarter dated 1/21/14, docum participate in pen pal unable to do arts and does appear to enjoy others while these ac The resident participate bingo the auxiliary vo one in helping the resresident appears to e resident participated imeetings, and bible s participated in outings special meals or dinn birthday parties, and will participate in spor	rly Activity Assessment, nented the resident doe time. The resident was crafts himself/herself be the interaction of being tivities are being perforated in bingo, during we lunteer staff will work or sident play bingo. The njoy this activity. The in resident council, care tudy. The resident s (a van ride). Furthermer parties at the facility, holiday dinner. The resident	ut ut with med. ekly ne on e plan ore,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ANDERSO	ON COUNTY HOSPITA	L LTCU	421 S M	APLE ST-PO	O BOX 309			
			GARNE	TT, KS 660	32			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 248	Continued From page 4			F 248				
F 248	gospel music. The rest activities: one to one, men's coffee. The rest spending time with the facility purchased a replayer for his/her roor enjoy the interaction way. Volunteer/Staff Smanicures, grooming. Affecting Participation cognition. For behavior came to live here he/sto behavior issues. The appears to be very harmonic to be very harmonic to be active to be a properly for the properly of t	sident participated in ot independent activities, sident appears to enjoy e facility bunny rabbit. Tew CD (compact disc) m. The resident appear with staff in a very posit Services: hair care, and shopping. Factors in: illness, vision, and for: when the resident fileshe had many different resident now laughs are appy. Activity Calendar wing activities: one exercises (no time and 1 on 1 exercises. It remained in his/her rome visits. However, the his/her room. dy, and at 3:00 PM small resident remained in his/one exercises (no time one exercises, and again his/her room. d on 12/15/14 at 10:00 in the dining area the t	and The ed to tive s rst and oom. e all is/her ent ain	F 248				
	a group played bingo resident was not inclu Furthermore, the resid	in the dining area the t	he e one					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/23/2	2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
ANDERSO	ON COUNTY HOSPITA	L LTCU	421 S N	IAPLE ST-PO	O BOX 309		
			GARNE	TT, KS 6603	32		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 248	Continued From page	e 5		F 248			
. 2.0	study at 2:30 PM.			. 2.0			
	Study at 2.00 T W.						
	Observations revealed on 12/16/14 at 9:14 AM, the resident sat in his/her wheelchair in his/her room, in front of a bedside tablet holding a stuff animal. The door to the residents room was halfway closed and the resident's CD player not turned on. At 10:26 AM, the resident remained unchanged. On 12/16/14 at 2:20 PM, the resident sitting in						
	On 12/16/14 at 2:20 PM, the resident sitting in front of the window in his/her wheelchair holding a stuffed cat in his/her hand. The resident's side of the room contained a CD player, approximately 10 CD's, and also numerous DVD 's and a set of head phones lying beside the bed. The CD player was not turned on.						
	On 12/16/14 at 3:40 PM, the resident back in his/her room, in his/her wheelchair, in front of the window holding a stuffed cat, and at 4:15 PM, the resident remained unchanged from the previous observation. On 12/17/14 at 8:30 AM, the resident sat in his/her room in front of a bedside table in a wheelchair, holding a stuffed cat. There was not any music playing, and at 9:30 AM, and 10:19 AM observations revealed no change in the resident.						
			9 AM				
	stated he/she visited of family members to see The resident's family resident liked to watch however the resident may need taken out sadapt games for the resident may need taken games for the	52 PM, activity staff C with the resident and hi e what his/her life was member informed staff h Walt Disney movies, can become excitable cometimes. The staff tricesident. Staff C stated abor to chart if a resident out if not, he/she will	like. the and es to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
				IAPLE ST-PO ETT, KS 660:				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 248	document in the quarresident likes to hold facility recently bough stuffed animal and a GStaff C stated he/she spend time with the reon ones 2 times a we do for the resident from On 12/16/2014 at 2:2 answered yes when at the sun, and does like was unable to state where identified. On 12/16/2014 2:25 a stated the resident will activities he/she likes does not come out for singing, during church comes out for exercises timulated and will haback to his/her room. his/her roommate will today though neither resident has a care planew the staff reads the on 12/16/2014 at 12: when a resident is ad an initial assessment. I will ask family what the resident oparticipating in, he/sh quarterly and yearly and on 12/16/2014 at 1:4	terly assessment. The the facility rabbit, and the facility rabbit, and the facility rabbit, and the for the resident a new CD play to listen to mush has a volunteer who we sident and he/she doe ek. The staff know what the care plan. O PM, the resident asked if he/she liked to be to listen to music, how what kind of music, the at PM, direct care staff all usually let us know what kind of music, the of the facility of the resident usually one and then becomes do usually have the radio one has	sic. sitill es one at to sit in vever J that nt over t r on, The n is stated vill do arly ner C re	F 248				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ANDERSO	ON COUNTY HOSPITA	L LTCU	421 S M	APLE ST-PO	O BOX 309			
			GARNE	TT, KS 660	32			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248	Continued From page 7			F 248				
	direct care staff will m dressed and toileted. specific activity on an communicate that info report. A CNA (certific will do the activity if the able to. On 12/17/14 at 8:45 A he/she did an assess the resident was due	lake sure the resident wanted a other shift, the staff wo ormation during shift ched nurses aide) on the face AD (activity director) AM, activity staff C statement in January, 2014, for an annual assessm	a uld ange floor is not ed and ent in					
	July, 2014, however he/she evidently did not do one. Furthermore, staff C does quarterly assessments when administrative nursing staff A gives him/her a schedule of when they are due. On 12/17/14 at 10:44 AM, direct care staff E stated the resident will hold his/her stuffed animal, likes to look out the window. Staff E will turn on music for the resident. Furthermore, staff E knows what to do for the resident from the care plan and the resident will ask the resident. On 12/17/2014 at 9:12 AM, activity staff C stated the resident did not receive any one on one on 12/16/14. On 12/16/2014 at 2:47 PM licensed nursing staff B stated the resident likes the rabbit, but can not place the resident too close to the rabbit because of a allergy. The resident likes to listen to music.							
			will staff					
			not ause					
	staff A state he/she di activities assessment there a care plan for a CAA did not trigger. F facility has 30 residen	n 12/17/14 at 8:42 AM, administrative nursing aff A state he/she did not see any further stivities assessments in the computer, nor is ere a care plan for activities because the activity AA did not trigger. Furthermore, stated the cility has 30 residents, the CNA's know of stivities by word of mouth or the communication						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE D PLAN OF CORRECTION IDENTIFICATION NUM		CLIA ,		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/23/2	2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
ANDERSO	ON COUNTY HOSPIT	AL LTCU		APLE ST-PO				
			GARNE [*]	TT, KS 6603	32			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
F 248	Continued From pa	ge 8		F 248				
	N stated the resider plays a lot of music, resident will come o residents roommate The staff also open	06 PM, licensed nursing at held stuffed animals, a especially at night. The ut for singing activities. The has the radio on every the blinds for the resider ified he/she reviewed the odated.	The night.					
	The undated facility Comprehensive Assessment and Care planning Policy, documented for scheduling the care plan will be completed on admission (within 14 days). An individual care plan will be developed/reviewed for each resident with documented measurable goals and outcomes within 7 days from completion of their MDS assessment. The RAI (resident assessment indicator) process (MDS & CAAS) is the basis for care plan decision making. This decision will be made by the RN (registered nurse) coordinator but is a combined effort of the members of the interdisciplinary team.		on re sident heir AS) is					
	10/19/04, document assessed upon adm quarterly during the This assessment wi types of interests ar currently pursues, a resident would like t available at the facil the resident's prefer which activities the reparticipate in (indepthis is done, and indeveloped. The doc daily attendance at a	r activities program, date and the resident will be alission, and a minimum of comprehensive assessful determine the amount and activities that the residence will as activities the opursue that are not curity. In addition, it will assured activity settings, and resident would prefer to endently or with others). Iividual activity plan will be umentation of the residence activities will be documed to the compation form and maintant.	of ment. and dent rrently sess Once pe ent's nted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
				MAPLE ST-PO ETT, KS 660:				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 248	in the Activity Director activity progress will be Social Services Progresident's chart. The facility failed to practivities for this resident's highest pramental, and psychosometric progressident's highest pramental, and psychosometric progressident (#12) to 10/25/13, found on the order sheet) dated on Alzheimer disease (pideterioration characters)	r's office. Documentation of made quarterly in the ress Notes section of the rovide individualized lent to enhance the cticable level of physical well being. diagnoses when admitted the signed POS (physicial 11/4/14, included: rogressive mental erized by confusion and	e le al, ed on an	F 248				
	state characterized by sadness, worthlessne osteoarthritis (degene many joints character and HTN (Hypertensipressure). The residents annual dated on 11/4/14, revadequate hearing and understood by others. The resident had a Bl	erative changes to one of ized by swelling and particle on elevated blood MDS (minimum data see aled the resident had division. The resident wand understands other MS (Brief interview of	of or ain), et), vas					
	had moderately impained a mood score of had minimal depressing daily and intruded on others. It was not very to read books, newsp somewhat important to things with groups of	of 6, indicating the residence cognition. The residence, indicating the residence. The residence con. The resident wander the privacy of activities of important for the residence apers or magazines. It is onlisten to music, doing people and participate was very important to be	dent nt ered of dent was I					

Printed: 12/23/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO ETT, KS 660				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 248	around animals such favorite activities, and when the weather is go keep up with the new independent with bed supervision with trans assistance of 2 staff vand dressing. The MDS did not trigg assessment dated on The residents CAA (cognitive loss/dement revealed the resident Alzheimer disease an cognition impairment. the wheelchair most opast history of behaviorsulting others, but heast last 90 days. The clinical record is due to the activities no MDS dated on 11/4/14. The plan of care, upd the resident needed to completion of directio surroundings PRN (as was to attend morning	as pets, doing his/her aget outside to get frest good, and not important s. The resident was amobility, required sfers, and required limits with walking, ambulation ger for activities from the 11/4/14. are area assessment) fitial, dated on 11/8/14, had a diagnosis of ad had moderate/severe. The resident wanders of the time. The resident ors such as striking and ad not been an issue for lacking CAA for activities of triggering from the aid at the control of the time. The resident wanders are such as striking and ad not been an issue for lacking CAA for activities of triggering from the aid ask segmentation to all ins and reorient to senecessary). The resident gannouncements for	ed n, e for e in with had dor at es nnual eled elew elent	F 248	DEFICIENCY			
	frustration or behavior staff are to do activities decrease risk of anxies activities daily and en morning announcement resident to attended a particularly enjoy. Pro	ct the resident if display rs to degrees agitation. es with the resident to ety and wandering. Inviticourage participation ir ents. Remind and encounctivities that the reside evide room visits when the great to descript the second to activities. Respect	The te to the					

HQBI11

NAME OF PROVIDER OR SUPPLIER ANDERSON COUNTY HOSPITAL LTCU (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 11 residents right to refuse, offer activities as choices between two events. The quarterly activity assessment will be documented to update the residents interests. Encourage the resident to attend activities like silverware wrapping and others which he/she might appear to be able to volunteer his/her services. The activity calendar for December, revealed planned activities on 12/16/14: One on one exercises un-timed, and this resident remained in bed. 10:30 AM - Card bingo, and this resident remained in loed. 10:30 PM - Care plans, which are not resident activities. 3:00 PM ball toss, which the resident refused.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
ANDERSON COUNTY HOSPITAL LTCU (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 248 Continued From page 11 residents right to refuse, offer activities as choices between two events. The quarterly activity assessment will be documented to update the residents interests. Encourage the resident to attend activities like silvenware wrapping and others which he/she might appear to be able to volunteer his/her services. The activity calendar for December, revealed planned activities on 12/16/14: One on one exercises un-timed, and this resident remained in bed. 10:30 AM - Card bingo, and this resident remained in bed. 10:30 PM - Care plans, which are not resident activities.			17E577		B. WING		12/2	3/2014	
CARNETT, KS 66032 CACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY TAG CEACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DATE F 248 Continued From page 11 residents right to refuse, offer activities as choices between two events. The quarterly activity assessment will be documented to update the residents interests. Encourage the resident to attend activities like silverware wrapping and others which he/she might appear to be able to volunteer his/her services. The activity calendar for December, revealed planned activities on 12/16/14: One on one exercises un-timed, and this resident remained in bed. 10:30 AM - Card bingo, and this resident remained in bed. 11:30 PM - Care plans, which are not resident activities.	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 11 residents right to refuse, offer activities as choices between two events. The quarterly activity assessment will be documented to update the residents interests. Encourage the resident to attend activities like silverware wrapping and others which he/she might appear to be able to volunteer his/her services. The activity calendar for December, revealed planned activities on 12/16/14: One on one exercises un-timed, and this resident remained in bed. 10:30 AM - Card bingo, and this resident remained in bed. 10:30 PM - Care plans, which are not resident activities.									
residents right to refuse, offer activities as choices between two events. The quarterly activity assessment will be documented to update the residents interests. Encourage the resident to attend activities like silverware wrapping and others which he/she might appear to be able to volunteer his/her services. The activity calendar for December, revealed planned activities on 12/16/14: One on one exercises un-timed, and this resident remained in bed 9:30 AM - Card bingo, and this resident remained in bed. 10:30 AM - Large group exercises, and the resident refused due to getting up. 1:30 PM - Care plans, which are not resident activities.	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	IOULD BE	COMPLETION	
On 12/17/14, the following activities scheduled for the day; 9:30 AM - Small group (B &D), and the resident remained in bed. un-timed, one and one activity, the resident was in bed. un-timed, nail care, the resident was in bed. un-timed mini fit group, and the resident remained in bed. 2:00 PM - Silverware wrapping. 3:00 PM - Lets sing Christmas music and decorate Christmas cookies. 3:00 PM - Small group (A&C). The activity assessment, dated on 11/13/14, revealed past activity interests included; cards, rummy, games, Chinese checkers, crafts/arts, woodworking, sports, swimming, music, religious activity, watching TV, current activity interest are cards, visiting possibly one on one, music walking	F 248	residents right to refuchoices between two activity assessment with the residents interests attend activities like so others which he/she rivolunteer his/her serv. The activity calendar planned activities on One on one exercises remained in bed 9:30 AM - Card bingo in bed. 10:30 AM - Large groresident refused due 1:30 PM - Care plans activities. 3:00 PM ball toss, who On 12/17/14, the follothe day; 9:30 AM - Small grouremained in bed. un-timed, one and on in bed. un-timed, nail care, the un-timed minifit grouremained in bed. 2:00 PM - Silverware 3:00 PM - Lets sing Odecorate Christmas of 3:00 PM - Small grouremained in bed. The activity assessmerevealed past activity rummy, games, Chine woodworking, sports, activity, watching TV,	se, offer activities as events. The quarterly vill be documented to up is. Encourage the reside ilverware wrapping and might appear to be ablevices. for December, revealed 12/16/14: is un-timed, and this resident remains up exercises, and the to getting up. in which are not resident ich the resident refused wing activities scheduled p (B &D), and the resident resident was in bed. In p, and the resident wrapping. Christmas music and ookies. In p (A&C). ent, dated on 11/13/14, interests included; cardese checkers, crafts/art swimming, music, religicurrent activity interests	ent to I I I I I I I I I I I I I I I I I I I	F 248				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	23/2014
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANDERS	ON COUNTY HOSPITA	\L LTCU		MAPLE ST-PO ETT, KS 660:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REG ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 248	outdoors, watching T are in the morning, the early in the morning, the early in the morning, and the residents clinical activity assessments administrative nursing. On 12/17/2014 at 2:2 at the front door, look silverware wrapping wroom. On 12/17/14 at 3:15 F wandering the halls in propelling self while the cookie decorating waroom. On 12/17/2014 at 1:1 member, stated the redeclined, and he/she what he/she used to dengage the resident, full time assistant to home of the cookie decorating waroom. On 12/16/2014 at 12: stated when the resident in an initial quarterly and yearly at the resident and their likes and what their nactivities. He/she doeresidents are participal quarterly and yearly, the resident in anythin stay engaged for very and watch someone of participate. The residents.	rV. activity time preference resident likes to get us and prefer outside activity record lacked any quarasince admission, which g staff A confirmed. 2 PM, the resident is siting out the door while the was in progress in the desired progress in the desired progress in the distribution of the confirmation	trerly tting he lining d ing mily oing to ded a acility, I ask nt s to at the hart gage hot l set	F 248			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	LE CONSTRUCTION	(X3) DATE SUF COMPLET			
		17E577		B. WING	· · · · · · · · · · · · · · · · · · ·	12/2	3/2014		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
ANDERSO	ON COUNTY HOSPIT	AL LTCU		APLE ST-PO FT, KS 6603					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 248	seem interested in a to reminisce, look at through a trinket box sensitive with his/he to lay down a lot. It is participate. The staff encourage him/her to resident does not lik unless he/she is slee by himself/herself, if with activities the staff the paper work of have any time to do the scheduled activity assisting on the flood caught up on them. On 12/16/2014 at 1: stated If the resident the staff will make so dressed and toileted specific activity on a communicate that in resident needs directlikes wandering in him we do have to help, and we have to keep activity, the resident confused. The resident confused. The resident the/she will not skeep his/her attentic time was when his/her.	anything. The staff have a picture books and go at. The resident is very a hearing. The resident It varies on how often he/s of will ask him/her and to come to activities. The set to be in him/her room eping, the resident likes is he/she is not participating. 43 AM, activity staff C, see for why the quarterly ethink that it is more the aides on the floor the done. He/she really did rothe assessments, betweeties, transportation and rother, he/she could not keep at wants to go to an activities that it is more the wants to go to an activitie that the resident wanted another shift, the staff was a shift change report. The stinct to the activity, he/slis/her wheelchair. Some the resident loses interest that is invited to the activitien activities, there are no activitien with the activities, the	ikes he to be on stated did n to not een D, ty, a puld een times est, and ities, es to only	F 248					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E577		B. WING		12/2	23/2014		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
ANDERSO	ON COUNTY HOSPITA	L LTCU		APLE ST-PO TT, KS 660:					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 248	stated the resident wi the staff assisted the The resident does not he/she is asleep. The room and ask the resattend the activity. On 12/18/2014 at 9:4 stated the staff will tal but then he/she will lespan was very short. of the time. The staff to every activity. The stay long, but if he/sh come. On 12/16/2014 at 2:4 B, stated the resident span. The resident to pay really likes pop corn a resident refuses anyth the nurse, so that and tried with the resident auxiliary staff is to assist at the auxiliary staff is to assist at the staff will take the resident the staff will take the resident enjoys of will let the residents k going on. The residents will resident sk going on. The resident with residents k going on. The resident with the resident will resident the resident will resident the resident will resident the resident k going on. The resident will resident the resident will resident the resident will resident the resident k going on. The resident will resident will resident will resident will resident k going on. The resident will resident will resident will resident k going on. The resident will resident will resident will resident will resident k going on. The resident will	Il come out to the movine resident to the activities under the activities under the staff will go to the resident if he/she would like the factor of the fac	s. nless dents de to M, vity, ention most ome not ill not staff cion hard at lef the aff tell e hat n CNA e floor staff cpan, and eave. e staff s The	F 248					

TAG OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 15 On 12/17/2014 at 12:09 PM, administrative nursing staff A, stated he/she was able to find the residents initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment.		OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING		(X3) DATE SURVEY COMPLETED	
ANDERSON COUNTY HOSPITAL LTCU 421 S MAPLE ST-PO BOX 309 GARNETT, KS 66032 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 15 On 12/17/2014 at 12:09 PM, administrative nursing staff A, stated he/she was able to find the residents initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment.			17E577		B. WING		12	/23/2014
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 15 On 12/17/2014 at 12:09 PM, administrative nursing staff A, stated he/she was able to find the residents initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment.	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 15 On 12/17/2014 at 12:09 PM, administrative nursing staff A, stated he/she was able to find the residents initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment.	ANDERSO	ON COUNTY HOSPI	TAL LTCU					
On 12/17/2014 at 12:09 PM, administrative nursing staff A, stated he/she was able to find the residents initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
The activity director needs to be charting that the residents are participating in an activity quarterly and daily. The quarterly assessments should be done when the care plan meeting was being discussed. The facility activity policy, dated on 10/19/04, revealed that each resident will be assessed upon admission, and a minimum of quarterly during the comprehensive assessment. This assessment will determine the amount and types of interests and activities that the resident currently pursues, as well as a activities the resident would like to pursue that are not currently available at the facility. In addition, it will assess the resident would prefer to participate in (independently or with others), once this is done, an individual activity plan will be developed. The documentation of the resident's daily attendance at activities will be documented on the activity participation form and maintained in the activity participation form and maintained in the activity failed to provide an individualized activity failed to provide an individualized activity programs will be made quarterly in the social services progress notes section of the resident's chart. The facility failed to provide an individualized activity program that met this cognitively impaired and dependent resident's physical, mental and psychosocial needs.	F 248	On 12/17/2014 at 1 nursing staff A, stat residents initial assiadmission, but he/s evidence of any quarthe activity director residents are partic and daily. The quardone when the care discussed. The facility activity prevealed that each upon admission, and during the compreh assessment will defor interests and act currently pursues, a resident would like available at the faci the resident's prefeactivities the reside in (independently of done, an individual The documentation attendance at activity director's of progress will be maservices progress in chart. The facility failed to activity program that and dependent resipsychosocial needs	2:09 PM, administrative ted he/she was able to fir essment from the resider she could not find any arterly activity assessment needs to be charting that ipating in an activity quarterly assessments should be plan meeting was being policy, dated on 10/19/04 resident will be assessed a minimum of quarterly assessment. This termine the amount and ivities that the resident as well as activities the to pursue that are not cutility. In addition, it will asserted activity settings and the would prefer to participant with others), once this is activity plan will be deveron of the resident's daily ities will be documented in form and maintained in activity plan will be deveron of the resident's daily ities will be documented in form and maintained in a form and maintained in the social and the provide an individualized at met this cognitively implication.	nts nt. at the rterly d be g I, d y s stypes rrently sess which pate s loped. on the the activity lent's d paired and	F 248			

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	
		17E577		B. WING		12	/23/2014
NAME OF PROVIDER OR S	UPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	-	
ANDERSON COUNT	Y HOSPITA	AL LTCU		IAPLE ST-PO TT, KS 660			
(X4) ID PREFIX TAG (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
11-07-14, facility, on The Signi dated 5-3 complete status). Twith mem term mem very impo involved in music and The CAA' 5-31-14, of The care bring the isocial intermorated the social intermorated and graders where the social intermorated in activity was according not been in activity of The reside show.	ficant Chan- ficant Chan- 1-14, revea a BIMS (bri The staff inter ory problem nory loss. Tour and to have a did not trigger for action. The staff inter ory problem nory loss. Tour and to have a did not trigger for action. The staff inter action discussion at the discussion at the resident to lear action. The staff inter action discussion at the resident to lear action. The staff interest in the resident in his/heas going on a to direct cal action direct	ge MDS (minimum dataled the resident unable of interview for mentalerview revealed the resident of the MDS also revealed of a family or a close frience of the family of the fam	a set), to dent g it is d ten to e. 4-14, and fth cility. had	F 248			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLET			
		17E577		B. WING	 	12/2	23/2014		
	OVIDER OR SUPPLIER ON COUNTY HOSPITA	AL LTCU	421 S N	DDRESS, CITY, STATE, ZIP CODE MAPLE ST-PO BOX 309 NETT, KS 66032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 248	member stated they in the resident's room channel. On 12-17-14 at 12:59 stated, the resident of activities outside of home of the facility does an interest that staff do resident does but the quarterly assessment to state that staff do resident does but the the quarterly or yearl stated the resident ty television. On 12-18-14 at 8:05 staff A, stated he/she explore more options resident. The facility policy for indicated documenta attendance at activitic Activity Participation Activity Director's Off The facility failed to pactivities to meet the resident.	5 a.m., the resident's far would like for the televis in to be left on the Hallm 9 p.m., direct care staff does not participate in his/her room. 3 p.m., activity staff C statical activity assessment is admission. After that is done. Staff C continuot chart each activity a estaff may get them addly assessment. Staff C prically just likes to water a.m., administrative nurse feels the facility should a for activities, effective 10-action of the resident's dates will be documented of Form and maintained in fice.	tated, ta	F 248					
SS=D	COMPREHENSIVE A facility must use th		nent	. 213					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/3	23/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ΓE, ZIP CODE			
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO TT, KS 6603				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From page	e 18		F 279				
	comprehensive plan	of care.						
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.							
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).							
	This Requirement is not met as evidenced by: The facility reported a census of 27 residents with 15 selected for review. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 2 of the 15 sampled residents reviewed (#26 and #18) for activities.							
	11/4/15, documented 7/1/13, with the follow Syndrome (chromoso characterized by vary retardation and multip dementia (progressive	ing degrees of mental ble defect), blindness, a	on and					

Printed: 12/23/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	
		17E577		B. WING		12	/23/2014
NAME OF PR	OVIDER OR SUPPLIER	OVIDER OR SUPPLIER STRE		ESS, CITY, STA	TE, ZIP CODE		
ANDERSO	NDERSON COUNTY HOSPITAL LTCU			APLE ST-PO TT, KS 6603			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MU OR LSC II		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	The annual MDS (m 7/9/14, revealed the vision, and wore cor with short/long term severely impaired do interview for activity resident determined to music he/she liked as pets, do things w residents favorite active fresh air when the w participate in religious was not important to and magazines to renews. The resident rassistance for walkin staff assistance for the for mobility. The CAA (care area for cognition documed diagnosis of Downs dementia. The reside ability to recall some Dementia is associal later years of life, and continued decline. The resident is legally can see outlines and The CAA for ADL's in guidance with transform the process of the proces	inimum data set), dated resident had highly imprective lenses. The resident memory problem, and ecision making. The resipreferences revealed the it was very important to do, be around animals, suith groups of people, do tivities, go outside to geteather is good, and us services or practices; a have books, newspapered, and keep up with the required extensive staffing and locomotion; limiter ansfers and used whee assessment), dated 7/1 ented the resident with a Syndrome and associate ent has been showing the of the staff names. The CAA for vision reveat the capture of the staff names of the capture of the staff names. The CAA for vision reveat the samples, but not much of the capture of the staff names of the capture of the staff names. The CAA for vision reveat the samples, but not much of the samples, but not much of the staff name of the capture of the samples, but not much of the samples, but not much of the samples, but not much of the samples of the samples of the samples of the samples.	aired dent dent e listen uch the t and rs, e ed elchair 5/14 a ed ne me in led ident else. uired no	F 279			

HQBI11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E577		B. WING		12/:	23/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	L LTCU		MAPLE ST-P			
			GARNE	TT, KS 660	32		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 279	Continued From page	e 20		F 279			
1 273	The care plan lacked this resident with spe- blindness and Down's	a individualized activition cial needs related to s syndrome.		1 213			
	7/9/13, documented to interest was music, wo older cartoons and older resident was kind of at to be an Elvis fan, most Activity Interests: must Activity time preferenciater, and prefers activity and prefers activity the quarter dated 1/21/14, documents of the quarter dated 1/21/14, documents was music.	activity assessment, date the resident's past activity atching television, enjor der television shows. The loner, his/her hobby usovies, and cartoons. Cursic, and watching televisiones: the resident was a livities in activity room.	ity ys he sed rrent sion. late				
	participate in pen pal unable to do arts and does appear to enjoy others while these ac The resident participating the auxiliary vo one in helping the resident appears to e resident appears to e resident participated i meetings, and bible s participated in outings special meals or dinn birthday parties, and will participate in spor spiritual/religious actingospel music. The reactivities: one to one, men's coffee. The respending time with the facility purchased an player for his/her roor enjoy the interaction way. Volunteer/Staff St	time. The resident was a crafts himself/herself by the interaction of being stivities are being performated in bingo, during we alunteer staff will work of sident play bingo. The enjoy this activity. The in resident council, care study. The resident is (a van ride). Furtherm her parties at the facility, holiday dinner. The resistent exercise. For vity, the resident enjoys sident participated in official independent activities, sident appears to enjoy he facility bunny rabbit. The we CD (compact disc) m. The resident appears with staff in a very positivities are being the control of th	put y with med. ekkly ne on e plan ore, ident her and The ed to ive				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB		JLIA (LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO TT, KS 6603			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	Affecting Participation cognition. For behavior came to live here he/s behavior issues. The appears to be very harmonic that the following of the resident was in his At 1:30 PM, one on ohis/her room. At 2:30 PM bible studgroup, the resident was in his room. At 2:30 PM bible studgroup, the resident was in his room. At 10:30 AM, large gr was in his/her room. On 12/16/14 at 10:00 the dining area, the trin the group. Furthermincluded in the one or or the group activity for the residents room was resident's CD player the resident remained. On 12/16/14 at 2:20 F	a: illness, vision, and or: when the resident fileshe had many different resident now laughs are appy. Activity Calendar wing activities: one exercises (no time and 1 on 1 exercises too sold filesher room. The visits, the resident in the day, and at 3:00 PM smalas in his/her room. The visits, the resident in the at 9:30 AM, the resident was not include at 9:30 AM, the resident was not include a proper the resident was not include the resident observable the room, in front of the resident observable the room, in front of the resident observable the room, at 10:26 the unchanged. PM, the resident sitting of the resident sitting of the resident sitting and the resident sitting of the resident sitting	day, all ent dent dent Moded not PM, M. red in f a por to the f AM,	F 279			
		his/her wheelchair hold nand. The resident's sid					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		CLIA		E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	17E577		B. WING		12/2	23/2014	
NAME OF PROVIDER OR SUPPLIER ANDERSON COUNTY HOSPITAL	LTCU		RESS, CITY, STAT				
		GARNE	TT, KS 6603	32			
PREFIX (EACH DEFICIENCY MUST E	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REG NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
the room contained a C 10 CD's, and also nume head phones lying besi was not turned on. On 12/16/14 at 3:40 PM his/her room, in his/her window holding a stuffer resident remained unch observation. On 12/17/14 at 8:30 AM his/her room in front of wheelchair, holding a sany music playing, and no change in the resided. On 12/16/2014 at 12:52 stated he/she visited wifamily members to see The resident's family members to see The resident liked to watch however the resident camay need taken out so adapt games for the resident likes to remember attended an activity, but document in the quarter resident likes to hold the facility recently bought stuffed animal and a CI Staff C stated he/she hispend time with the resident from On 12/16/2014 at 2:20 answered yes when as the sun, and does like the was unable to state who	CD player, approximate erous DVD 's and a serice the bed. The CD point of the bed in front of the bed in the previous of the bed in the bed i	et of blayer In of the line ous In ot les AM Is/her like. the less to less to less to less to less one	F 279				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C		. ,	LE CONSTRUCTION	(X3) DATE SU			
AND PLAN O	CORRECTION	IDENTIFICATION NUMBE	K.	A. BUILDING		COMPLE	IED		
		17E577		B. WING		12/2	23/2014		
NAME OF PR	OVIDER OR SUPPLIER	ER OR SUPPLIER STREET ADDRESS, CITY, STATE, Z		TE, ZIP CODE					
ANDERSO	ON COUNTY HOSPITA	IL LTCU		1 S MAPLE ST-PO BOX 309					
			GARNE	TT, KS 660	32 				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	Continued From page resident liked. On 12/16/2014 2:25 a stated the resident will activities he/she likes does not come out for singing, during church comes out for exercis stimulated and will haback to his/her room. his/her roommate will today though neither resident has a care planew the staff reads the On 12/16/2014 at 12: when a resident is ad an initial assessment. I will ask family what the residenormal routine in regardoes not chart daily oparticipating in, he/sh quarterly and yearly a On 12/16/2014 at 1:4 reported a resident will direct care staff will me dressed and toileted. specific activity on an communicate that info	e 23 at PM, direct care staff of a lusually let us know who or dislikes. The resident is bingo, but will come out an end of the resident is and then becomes of the resident usually or usually have the radio one has the radio on	J hat hat hat out for ent over t on, he his stated vill do arly her c e		CROSS-REFERENCED TO 1	THE APPROPRIATE			
	able to. On 12/17/14 at 8:45 A he/she did an assess the resident was due	AM, activity staff C statement in January, 2014, for an annual assessme/she evidently did not aff C does quarterly	ed and ent in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
	17E5			B. WING		12/23/2014		
						12/2	3/2014	
			RESS, CITY, STA					
ANDERSO	ON COUNTY HOSPITA	AL LTCU		IAPLE ST-PO ETT, KS 6600				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	9 Continued From page 24			F 279				
. 2.0	assessments when administrative nursing staff A gives him/her a schedule of when they are due.			. 2.0				
	On 12/17/14 at 10:44 AM, direct care staff E stated the resident will hold his/her stuffed animal, likes to look out the window. Staff E will turn on music for the resident. Furthermore, staff E knows what to do for the resident from the care plan and the resident will ask the resident.							
	On 12/17/2014 at 9:12 AM, activity staff C stated the resident did not receive any one on one on 12/16/14.							
	B stated the resident place the resident too	7 PM licensed nursing likes the rabbit, but can close to the rabbit beclent likes to listen to mu	not ause					
	On 12/17/14 at 8:42 AM, administrative nursing staff A state he/she did not see any further activities assessments in the computer, nor is there a care plan for activities because the activity CAA did not trigger. Furthermore, stated the facility has 30 residents, the CNA's know of activities by word of mouth or the communication book.							
	N stated the resident plays a lot of music, e resident will come out residents roommate h The staff also open th	6 PM, licensed nursing held stuffed animals, a especially at night. The t for singing activities. Thas the radio on every role blinds for the residented he/she reviewed the dated.	nd The night. It to					
	and Care planning Po	Comprehensive Assessi olicy, documented for lan will be completed o						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	17E577 B. WING 12/23/20		23/2014					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANDERS	ON COUNTY HOSPITA	L LTCU		MAPLE ST-PO ETT, KS 660				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	admission (within 14 plan will be developed with documented measured outcomes within 7 da MDS assessment. The assessment indicator the basis for care plandecision will be made nurse) coordinator bus members of the intercomplete of the intercomplete of the physical form. The facility failed to docomprehensive care president for activities. - Review of the physical form. The Significant Change dated 5-31-14, revealed refacility, on 9-15-11. The Significant Change dated 5-31-14, reveal complete a BIMS (briestatus). The staff into with memory problem term memory loss. The very important to have involved in discussion music and to do thing the resident required staff for bed mobility, The CAA's (care area 5-31-14, did not trigged. The care plan, dated bring the resident to be sufficient to be sufficient to be sufficient or sufficient to be suffic	days). An individual card/reviewed for each resaurable goals and ys from completion of the RAI (resident) process (MDS & CAAn decision making. Thise by the RN (registered it is a combined effort or disciplinary team. evelop a individualized plan to include care for ician order sheet, dated esident #18, admitted to ge MDS (minimum dataled the resident unable ef interview for mental erview revealed the resident ef interview for mental erview revealed the resident and long the MDS also revealed if e family or a close frien as regarding care, to list is with groups of people total dependence of two transfers and dressing. a assessment), dated er activities. 12-03-14, directed staffarge group exercise for owever, the plan lacked	their S) is f the this their this dent g it is dent g it is dent g it is dent g it is dent f to e.	F 279				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
17E577			B. WING		12/2	3/2014	
NAME OF PROVIDER OR SUPPLIER STREET		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANDERSO	ON COUNTY HOSPITA	AL LTCU		IAPLE ST-PO ETT, KS 660:			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From page 26			F 279			
	documented the resideral crafts and also enjoys graders who visit the On 12-15-14 at 11:50 resting in bed in his/h activity of ball toss produced for the According to direct cannot been invited to particular to be an invited to particular to be an invited to particular to the activity is going on in resident's television where the activity is going on in resident's television where the activities and do his/her room. On 12-16-14 at 10:24 stated, the resident not group activities and do his/her room. On 12-17-14 at 11:15 member stated they win the resident's room channel. On 12-16-14 at 12:53 the facility does an initiate time of a resident's he will visit with the insee what it is the resident games to fit the that, quarterly assess continued to state the activity a resident does	assessment, dated 9-2 dent participated in arts is pen pals (a group of firesidents) are at the fart a.m., the resident was er room while a group occeded the dining roomer staff F, the resident articipate in the activity. D.m., the resident was es closed, while a group the dining room. The was tuned to a game show a mention and the farticipate in the activities in the activities in the activity of the farticipate in the staff of longer participated in the same, the resident's fart would like for the televist to be left on the Hallm of p.m., activity staff C staff activity assessment's admission. Staff C staff activity assessment is admission. Staff C staff activity assessment is same are done. Staff at staff do not chart each es each day, but it will derely or yearly assessment at staff do not chart each each day, but it will derely or yearly assessment at staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day, but it will call the staff do not chart each each day assessments.	and ifth cility. m. had p ow. K mily sion ark tated, t at tated s to d will er C h often				
	•	p.m., direct care staff					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBI		, ,	E CONSTRUCTION	(X3) DATE S COMPLE	
		17E577		B. WING		12/	/23/2014
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STAT	E, ZIP CODE	•	
ANDERSO	ON COUNTY HOSPI	ITAL LTCU		APLE ST-PC			
			GARNE	TT, KS 6603	2		
(X4) ID PREFIX TAG	SUMMAR\ (EACH DEFICIENCY M OR LSC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	Continued From p	age 27		F 279			
	activities outside of	f his/her room.					
	staff A, confirmed a documented on a construction of the staff and the s	05 a.m., administrative nuactivities were not being daily basis and that there a quarterly activity assess 4. Staff A stated that if the dactivities daily, it would and care plan more accure/she continued to state to ore more options for this care planning to be more needs and desires. effective 10-19-14, includivill be assessed upon minimum of quarterly during sessment. This assessment amount and types of inter	ement e help ate he e ed ng the ent				
F 280	and activities that the In addition, it will as activity settings, and would prefer to part with others). Once activity plan will be The facility failed to	the resident currently pursuessess the resident's prefered which activities the residently ethic is done, an individual edeveloped. Description of the developed of the developed include individualization in clude individualization.	sues. Irred ident or al	F 280			
	PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plann changes in care and A comprehensive of the participate in care and the	ANNING CARE-REVISE of the right, unless adjudged the right, unless adjudged the right for the laws of the State, to the care and treatment of the state.	r	1 200			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
	17E577			B. WING		12/2	3/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDR		RESS, CITY, STA	TE, ZIP CODE					
ANDERSO	ON COUNTY HOSPITA	L LTCU	421 S N	APLE ST-P	D BOX 309			
			GARNE	TT, KS 660	32			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 28		F 280				
	comprehensive assessinterdisciplinary team physician, a registere for the resident, and of disciplines as determined, to the extent prathe resident, the resident representative; a	ssment; prepared by an , that includes the atter d nurse with responsibilities appropriate staff in ined by the resident's nucticable, the participation dent's family or the resident's family or the resident periodically reviewed nucleof of qualified persons a	nding ility n eeds, on of dent's					
	This Requirement is not met as evidenced by: The facility identified a census of 27 residents. The sample included 14 residents. Based on observation, record review and interview, the facility filed to review and revise the care plan for 1 (#12) of the sampled resident for activities and accidents.							
	Findings included:							
	- Review of resident #12 's physician order sheet, dated 11-4-14, revealed diagnoses including: Alzheimer disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and HTN (Hypertension- elevated blood pressure).							
	dated 11/4/14, revealed with adequate hearing	I MDS (minimum data sed the resident assessed and vision, BIMS (Bratus) score of 6, indicate	ed ief					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
	17E577			B. WING		12/2	12/23/2014	
		STREET ADDR						
				APLE ST-PO FT, KS 660:				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	moderately impaired of indicating minimal depland intruded on the property interview revealed it with the resident to read by magazines, somewhat music, doing things with participate in religious important to be around doing his/her favorite fresh air when the we important to keep up was independent with supervision with transpassistance of 2 staff with and dressing. The MDS did not trigg assessment dated on the residents CAA (concentrated to consider the wheelchair most of the wheelchair most of past history of behavior insulting others, but heast last 90 days. The plan of care, upd the resident needed to completion, reorientation and state the resident if display agitation. staff advise resident to decrease wandering and encounter the wandering and encounter the wandering and encountered to the resident to decrease wandering and encountered to the resident to the resident to decrease wandering and encountered to the resident to the resident to decrease wandering and encountered to the resident t	cognition, mood score of pression, wandered dain rivacy of others. Family was not very important to ooks, newspapers or at important to listen to with groups of people and services and very dianimals such as pets activities, go outside to ather was good, and not with the news. The resident mobility, required offers, and required limit with walking, ambulation of the time. The resident wanders of the time. The resident wanders of the time. The resident ors such as striking and ad not been an issue for activities with the time advised to redire time frustration, behavior of the time and the resident wanders and not be an anissue for the time and the time to all the time and	illy for d get ot dent ed n, e for aled ow RN nts ect rs or ne	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	17E577 B. WING 12/23/2014		3/2014					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ANDERSO	ON COUNTY HOSPITA	L LTCU	421 S M	IAPLE ST-P	O BOX 309			
			GARNE	TT, KS 660	32			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 30		F 280				
F 280	enjoy, provide room verification of going to activities to refuse, and offer active events. The quart be documented to up interests. Encourage activities like silverway which he/she might a volunteer his/her serve the activity calendar revealed the following. One on one exercises in bed. 9:30 AM - card bingo, 10:30 AM - Large groof refused to go due to go time. 1:30 PM- Care plans. 3:00 PM - Ball toss, the Activities on 12/17/14, activities: 9:30 AM small group bed. Un-timed, one and on in bed. Un-timed, nail care, the Un-timed mini fit groud 2:00 PM - Silverware 3:00 PM - Lets sing Compared to the provided activities and the provided activities are the provided activities.	risits when the resident respect the residents of the respect the residents of the respect the resident's as choices between year activity assessment date the resident to attend rewrapping and others ppear to be able to rices. If or December 16, 2014 yeactivities: If or December 16, 2014	right veen nt will t was ed. ent this	F 280				
	decorate Christmas c 3:00 PM - small group							
	The activity assessme revealed past activity games, Chinese check	ent, dated on 11/13/14, interests of cards, rum	my,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	' '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/	23/2014	
NAME OF PROVIDER OR SUPPLIE	R		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANDERSON COUNTY HO	SPITAL LTCU			MAPLE ST-PO ETT, KS 660:				
PREFIX (EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
cards, visiting poutdoors, water are in the morn early in the morn data of the silverware of the silve	m page 31 ng TV, current activit nossibly one on one, hing TV. activity time ing, the resident like rning, and prefer out: dinical record lacked ments since admissic dministrative nursing at 2:22 PM, the resident door, looking out vrapping was in progra 3:15 PM, the resident halls in his/her whee herself while the Chrorating was in progra at 1:19 PM, the resident lethe residents cogni e/she was not intere ed to do. Activity sta dident, but activity sta dident, but activity sta ident, but activity ident, but a	music was e preferer s to get u side activities. It is eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the eresider in regards illy on what is even to engres in the e	alking nces prices prices. Terly as while ne usic enterly being to led a led a led then led the art age ot set	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
			i.c.			33 22.125		
		17E577		B. WING		12/2	3/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE,		TE, ZIP CODE						
ANDERSO	ON COUNTY HOSPITA	AL LTCU		IAPLE ST-PO				
			GARNE	TT, KS 660	32			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 280	0 Continued From page 32			F 280				
F 280	participate. The reside the halls in the wheele seem interested in an to reminisce, look at put through a trinket box. sensitive with his/her to lay down a lot. It vaparticipate. The staff encourage him/her to resident does not like he/she was sleeping. On 12/18/2014 at 8:4 he/she had no excuse not get done. He/she important to assist the get the paper work do have any time to do the scheduled activitie assisting on the floor, caught up on them. On 12/16/2014 at 1:4 stated If the resident of the staff will make sur dressed and toileted. specific activity on an communicate that in seriodent needs directed to the activity together puzzle and confused. The resident activities, but he/she activities to keep his/he activities to keep his/he	ent likes to go up and de chair. The resident doe hything. The staff have to cicture books and go The resident is very hearing. The resident liaries on how often he/slewill ask him/her and come to activities. The to be in his/her room us as AM, activity staff C, see for why the quarterly of think that it was more to activity aides on the floor there are aldes on the floor there are aldes on the floor there as a sessments, between the could not keep a see, transportation and he/she could not keep a fifther resident was up, If the resident wanted a cother shift, the staff wo shift change report. The finn to the activity, he/she/she/she wheelchair. Staff E sees interest and has to be an activity and get very irritated and the was invited to the will not stay. There are	s not tried kes he inless tated did n to ot een D, ty, a uld e he b be titting d no	F 280				
	was here. On 12/17/2014 at 2:5	6 PM, direct care staff (G.					
		, aoct oaro otali v	-,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO TT, KS 660			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	stated the resident withe staff assisted the The resident does no he/she was asleep. Tresidents room and a would like to attend the On 12/18/2014 at 9:4 stated the staff will tabut then he/she will lespan was very short. of the time. The staff to every activity. The stay long. On 12/16/2014 at 2:4 B stated the resident span. The resident to pay really likes pop corn a resident refuses anyth the nurse, so that and tried with the resident auxiliary staff was to a there was a big activity. CNA on the floor to as floor to answer the cadepartment needed at On 12/17/2014 at 3:0 N, stated the resident the staff will take the with in a couple of min The resident enjoys of will let the resident will sleep resident will sleep the resident will sleep.	Il come out to the moving resident to the activities of the staff will go to the sk the resident if he/shone activity. 6 AM, direct care staff like him/her into the activity. 6 AM, direct care staff like him/her into the activity asked the resident state. The resident wanders resident will come and asked the resident to corresident will come and a dementia and it was a very short attential dementia and it was a vattention. The resident and watching a movie. It hing he/she had the state of the staff made sure the assist with activities, which, he/she will schedule sesist and leave 2 staff could be sesist and leave 2 staff could lights when the activities is a short attention serious to the activity and the staff made sure the resident will leave at night wandering, the staff wanders all the time.	s. nless e M, vity, ention most ome not staff con hard at lift the aff tell e hat hen e a on the ty staff span, and eave. e staff vas The	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
17E577 B. WING		12/2	12/23/2014					
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
				IAPLE ST-PO TT, KS 660				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	resident 's initial asse admission, but he/she evidence of any quart. The activity director not residents are participal and daily. The quarter done when the care produced discussed. Furthermore, review of record, revealed the lawith fall interventions 12/1/14, for the residents quarter set), dated on 2/5/14, since the last assess intruded on the private resident was indepensupervision with transstaff with walking, am resident had 1 non injussessment dated on antipsychotic, antianx medications. The residents quarter reveled the resident hastaff with transfers and the last assessment on the further changes from the last assessment. The residents quarter revealed a BIMS (bries score of 99. The resident revealed a BIMS (bries score of 99. The resident plans and the last assessment.	I he/she was able to finessment from the reside e could not find any erly activity assessment eeds to be charting that ating in an activity quarry assessments should lan meeting was being of the resident's clinical ack of care plan revision following falls on 5/4/14 ent. Ity MDS (minimum date revealed a 1 non injuryment, wandered daily a cry of activities of others dent with bed mobility, effers, limited assistance bulation, and toileting. The sident was interpretable to the prior 8/4/14, the resident was interpretable and antidepressant ly MDS, dated on 5/6/1 and limited assistance of that 1 non injury fall slated on 2/5/14. There	ents Int. Int the terly of be and	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	17E577			B. WING		12/2	3/2014	
NAME OF PROVIDER OR SUPPLIER STREE		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO				
	0.18.84.857.03	FATELIEUE DE RESIDIENDIED		1			(YE)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280	Continued From page 35			F 280				
	the previous on asses	ssment.						
	The residents annual MDS, dated on 11/4/14, revealed the resident had 1 non injury fall since the prior assessment dated on 8/4/14.							
	Falls, dated 11/8/14,rd history of falls prior to documented on 8/29/related to safety awar on his/her part to use The resident was on a help alert staff of his/h decrease the resident resident does not use needs, but will try to cresident required staff safely and provide cu	are assessment area) to evealed the resident had admission. The last faread the interest and poor judger, a walker with ambulate a wireless personal alar ner movements and to the falls or injury. The enhis/her call light to report to the interest and to the fassistance to ambulate eing to keep the walker resident was a high risk admission.	ad a II was vas ment cion. rm to ort e te r in					
	resident needed task completion of direction surroundings PRN (as was to attend morning orientation and redire frustration or behavior task segmentation to directions, reorient the surroundings PRN, has morning announcement the resident if display to degrees agitation a wheelchair throughor present as an elopem resident was entering restrooms and require	s necessary). The resic g announcements for ct the resident if display rs to decrease agitation allow completion of	dent ying n. The direct viors els in s not ne					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/23/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	AL LTCU	421 S M	APLE ST-P	O BOX 309		
			GARNE [*]	TT, KS 660	32		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE- OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE COMPLETION	N
F 280	Continued From page	ge 36		F 280			
00		t had a potential for inju	rv due	00			
		kness. The staff are to					
		of clutter, the bed at the					
		ocked, bed control in re					
		dent required 1 staff for					
		ation, and is independer	nt in a				
		dent was to have a fall r					
	assessment quarterly	y, a falling star magnet	on				
		he side rails are to be up					
		ner bed per resident req					
	_	ent. Monitor for SE (side					
	effects) of medication	ns, pressure alarm in					
	wheelchair, bed and	recliner, and check pre	ssure				
	alarm function every	shift. The resident had	been				
	standing up and amb	oulating unassisted ever	n with				
	the alarm. The staff p	provided rapid response	e to				
	alarms and provide of	contact guard assist with	ו				
	most transfers/ambu	lation. The resident has	а				
	self care deficit relate	ed to dementia. The res	ident				
	can transfer and amb	bulate with a walker with	n a				
	gait belt and assistar	nce of 1 staff. Encourag	e				
		ng and daily hygiene. Tl					
	•	ach at all times. Toilet ar					
	I -	nt every 2 hours and PF	RN.				
		ist with completion of					
		ygiene, pericare and cha	ange				
	· ·	er per each incontinent					
	episode.						
	The plan of care lacked interventions for the resident's fall on 5/4/14.						
	revealed the residenthis/her room at the for personal alarm failed staff of the resident r	t investigation, dated 5/ t was found on the floor oot of the bed. The resid to sound, to alerting the movement. The safety k the reset icon on the ala m to shut off without	in dents e ey				
	sounding. The fall wa	as without injury. The st	aff				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SU	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	:K:	A. BUILDING		COMPLE	IED
		17E577		B. WING		12/2	23/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO			
			GARNE	TT, KS 660	32		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From page	e 37		F 280			
	Continued From page 37 was instructed to not leave the key in place on the alarm boxes to prevent malfunctioning of the device. The plan of care, updated on 8/29/14, included a						
	fall in the lobby on 8/2		cua				
		e without assistance. T	he				
		nal alarm in bed and in					
	wheelchair to alert sta	aff of his/her movement	s.				
	The facility complaint investigation, dated 8/29/14, revealed a non injury fall. The staff responded to a personal pressure alarm sounding and found the resident sitting in the commons area between his/her wheelchair unlocked and the couch. The staff provided frequent reminders to the resident to ask for staff assistance prior to transferring,						
		ers to lock the wheels of	- 1				
	-	nsferring. However, this					
	intervention would no	_					
	confused, forgetful re-	sident with repeated fal	I.				
	The facility lacked into fall on 12/1/14.	erventions for the reside	ent's				
	The facility complaint investigation, dated 12/1/14, revealed the resident stood up from the wheelchair and lost his/her balance and fell. The personal alarm sounded late, related to it being under the cushion and delayed its signal. The new intervention per administrative staff A, instructed the charge nurse, licensed nursing staff M, to conduct two or more sets of orthostatic blood pressures spread out to monitor if there was a change relating to lying down and standing up quickly or if he/she was suffering from hypotensive drops. The care plan will be charged back to placing the wheelchair alarm pad on top of the cushion to minimize risk of delaying the sound. However, this intervention lacked						

Printed: 12/23/2014 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N 17E			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/23	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	AL LTCU	421 S N	IAPLE ST-P	O BOX 309		
			GARNE	TT, KS 660	32		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	Continued From pag	je 38		F 280			
	communication to the staff with failure to be included on the care plan. The fall risk assessment quarterly, dated 4/26/14, revealed a score of 11, indicating the resident is a high fall risk The fall assessment, dated on 7/23/14, revealed a score of 12, indicating the resident is a high fall risk. Observation on 12/15/2014 at 4:01 PM, revealed the resident was resting in bed with his/her eyes closed. Both of the half side rails were up. The resident was laying on his/her right side in the bed. The resident has a wireless pressure alarm under the right hip, turned on.						
	Observation on 12/16/2014 at 1:43 PM, the resident was sitting in his/her wheelchair with the pressure alarm engaged, propelling him/herself down the hall and was looking out the door at the end of the west hall. Interview on 12/17/2014 at 1:19 PM, with the resident's family member, revealed the resident does not remember to ask for help. He/She has brought in a lot of non skid socks. He/She requested placement of the alarm put under the cushion of the wheelchair, but now it was on the top of the cushion.		self				
			lent has er the				
	top of the cushion. On 12/17/2014 at 2:49 PM, direct care staff G, stated the pressure alarms are to be in any seats and bed and the resident was to always have non skid socks. The alarm is to be under the big cushion on the chair. The resident is cognitively impaired. He/She thinks the resident is too independent to push the call light and ask for help. The resident is unable to remember		seats e non /ely				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO TT, KS 660				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	anything for very shor are the resident is not the call light. When che push down before the was not aware of any the checking of the all reminding the resident appropriate intervention. On 12/18/2014 at 9:4 stated when the resident at the staff will push on the poff. The alarm was to bottom. The resident matter how much the The resident had non the time. On 12/17/2014 at 2:5 N, stated the resident does things for himse not sleep well at night likes to sleep in. The stop of the cushion. Thin the computer syste positioning of the alar slipper socks on at all monitor the slipper socks are on. The resimpaired, the intervento use the call light waintervention for the resinterventions for the N 2014 fall due to he/she education on fall prevente May 2014 fall The	t amount of time. Char going to remember to be a going to resident uses it. He/SI where that the staff charms. He/She did not that to use the call light whom for falls. 5 AM, direct care staff the and to make the alarm be right under the residual to make the alarm be right under the residual to make the call light staff reminds the residual socks that are on the staff. The resident and wanders a lot, the alarm pad was to be or the alarm was being charm. The nurses monitor m. The resident was to times. The nurses also cks to make sure that the dent was cognitive the times and appropriate sident. 5 PM, administrative nurses and appropriate sident.	use arm, he arts hink as an M, the go dent's at no ent. all staff and does en a the arted the chave of the dent ursing mber for ntion	F 280				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI			E CONSTRUCTION	(X3) DATE SI COMPLE	
		17E577		B. WING		12/	23/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE		
ANDERSON COUNTY HOSPITAL LTCU				APLE ST-PC TT, KS 6603			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RI OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	The resident tends socks in the bed. Intervention on the An intervention to reall light and ask for the medications with the fall could of bed that the resident was routinely review the investigations. The facility failed to resident's care plar activities and intervent repeated for the facility must errenvent repeated for the facility must errenvironment remains is possible; and adequate supervisity prevent accidents. This Requirement The facility had a completion and interview and interview implement intervention.	to kick off his/her slipper He/she did fail to put the care plan for the 12/1/14 remind the resident to use or assistance. He/she reviet a fall if it was indicated as on. He/she does not a residents medications or review and revise this in to include individualized rentions following falls to alls for this dependent res	fall. e the elews that ations n fall sident. zards es to	F 280			
	10/25/13, found on	2) diagnoses when admit the signed POS (physici on 11/4/14, included:					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E577		B. WING		12/2	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
		421 S N	IAPLE ST-P	O BOX 309			
			GARNE	TT, KS 660	32		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 41		F 323			
F 323	Alzheimer disease (pideterioration character memory failure), depristate characterized by sadness, worthlessner ostroarthritis (degene many joints character and HTN (Hypertensi pressure). The residents quarter set), dated on 2/5/14, since the last assessi interview of mental stresident had short ter problems. The reside intruded on the privace resident was indepensupervision with transstaff with walking, am toileting. The resident noted on assessment injury fall since the problems antianxiety and antide. The residents quarter reveled the resident his staff with transfers and staff with t	rogressive mental erized by confusion and ression (abnormal emoty exaggerated feelings as and emptiness), rative changes to one of ized by swelling and particle of the preventage on- elevated blood. The MDS (minimum date revealed a 1 non injuryment, revealed a 1 non injuryment, revealed a BIMS atus) score of 99. The mand long term memont wandered daily and by of activities of others dent with bed mobility, afters, limited assistance at had no pain indicators and the pressant medications. The resident had 1 notion assessment dated of the pressant medications. The MDS, dated on 5/6/1 and limited assistance of the pressant medications. The mand long term memons are seen and the pain indicators and the pain indicators are seen and the pain indicators are seen and the pressant medications. The mand limited assistance of the pressant medications and limited assistance of the pressant dated on 2/6/14. The pressant dated on 2/5/14. The ment dated on 2/5/14.	tional of of or ain), ed y fall (brief ory . The e of 1	F 323			
	revealed a BIMS (brie score of 99. The resid term memory problen injury fall since the las	ly MDS, dated on 8/4/1 of interview of mental statement had short term and the resident had 1 is assessment dated or any further changes from the statement.	tatus) d long non า				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E577		B. WING	<u>.</u> .	12/2	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	IL LTCU		IAPLE ST-PO ETT, KS 660			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 42		F 323			
	revealed the resident of mental status) scor resident had moderat	MDS, dated on 11/4/14 had a BIMS (Brief interer of 6, indicating that the ly impaired cognition. jury fall since the prior 8/4/14.	rview ne				
	cognitive loss/dement the resident had a dia and had moderate/se The resident demons regards to safety and wanders in the wheel- resident had past hist striking and insulting of had not been an issue	are assessment area) to take a state and the take a state and the take a state	aled sease ent. with ent The as rs				
	functional status, date resident had a diagnor and requires assistant resident had a history admission related to proceed the consistent use of safe. The resident requires segmentation to stay as dressing and hygie the hallways in his/he issue with entering of	on track with activities ene. The resident wand or wheelchair and had sher resident rooms. The falling related to the r	se The r to sk of on. such ers ome				
	Behavioral symptoms	are assessment area) f s, dated 11/8/14, reveal e behavioral issues with	ed				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E577		B. WING		12/2	23/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	L LTCU		IAPLE ST-PO ETT, KS 660			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From page			F 323			
F 323	wandering and invadi spaces. The staff will meet basic needs to	and other resident private attempt to redirect and ensure this was not relate at the resident is on sero ce a day, which had be times a day on 11/4/14 his/her issues have y was trying a GDR (grane resident. The resident area) for the resident has a day on 11/4/14 his/her issues have y was trying a GDR (grane resident. The assessment area) for the resident has a dission. The last fail 14. Most of the issue wereness and poor judgent, a walker with ambulate a wireless personal alaner movements and to the falls or injury. The shis/her call light to replate it on his/her own. The fassistance to ambulate eing to keep the walker resident was a high risk atted 11/14/14, revealed segmentation to allow and reorient to so necessary). The resident and resident if display resident to his/her ave the resident attendents for orientation, redicted.	ated quel, een 4, for adual for id a II was as nent ion. rm to ort e e in for d the lent lying i. The	F 323			
	the resident if display to degrees agitation.	ing frustration or behav The resident self prope out the facility, but does	iors Is in				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	CONSTRUCTION	(X3) DATE S COMPL	
		17E577		B. WING		12	/23/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	, ZIP CODE		
ANDERSO	ON COUNTY HOSPITA	AL LTCU		MAPLE ST-PO ETT, KS 66032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	resident was entering restrooms and required The staff are to contict closely. The resident to unsteady gait/weathe environment free lowest position and leat all times. The resident transfers and ambulated wheelchair. The residents door, the right side of his/he for mobility assessment quarterly the residents door, the right side of his/he for mobility assessmeffects) of medication wheelchair, bed and alarm function every standing up and ambute alarm. The staff palarms and provide comost transfers/ambuself care deficit related can transfer and ambuself care deficit related can trans	ment risk at this time. The gother resident's rooms ared redirection from staff inue to monitor him/her thad a potential for injurtakness. The staff are to be of clutter, the bed at the ocked, bed control in readent required 1 staff for ation, and is independent was to have a fall region, and is independent was to have a fall region, and is independent was to have a fall region. Monitor for SE (sidens, pressure alarm in recliner, and check presshift. The resident had boulating unassisted ever provided rapid response contact guard assist with a walker with the dealth of the staff. Encouraging and daily hygiene. The hat all times. Toilet and the very 2 hours and PF ist with completion of the staff. Encouraging and daily hygiene. The hat all times are per each incontinent dressing in the morning, pajama pants on when the staff of the staff. In the staff of the staff	s and if. ry due keep e ach It in a risk on o on uest e ssure been n with e to n a dent n a e ne call nd RN. ange , fall	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
	17E577		B. WING		12/2	3/2014	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
			IAPLE ST-PO ETT, KS 660:				
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
personal alarm failed staff of the resident m was positioned over the box causing the alarm sounding. The fall was was instructed to not alarm boxes to prevedevice. The plan of care, updifall in the lobby on 8/3 attempted to ambulate resident had a person wheelchair to alert state and frequent reminded wheelchair unstaff provided frequent to ask for staff assist and frequent reminded wheelchair before traintervention would not confused, forgetful reminded wheelchair and lost heresonal alarm sound under the cushion an new intervention per instructed the charge staff M, to conduct two	to to f the bed. The reside to sound, to alerting the novement. The safety kether eset icon on the alert to shut off without as without injury. The state of the leave the key in place on malfunctioning of the leave the key in place of the leave t	e ey arm aff on the e e ed a led a led to end ween The dent end	F 323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		17E577		B. WING		12/2	23/2014	
	OVIDER OR SUPPLIER ON COUNTY HOSPITA	L LTCU	421 S M	RESS, CITY, STA IAPLE ST-PO TT, KS 6603	O BOX 309			
(X4) ID PREFIX TAG			GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	was a change relatin up quickly or if he/she hypotensive drops. The back to placing the whof the cushion to mini sound. However, this communication to the included on the care provided the resident was revealed a score of 1 high fall risk. The fall assessment, a score of 12, indication risk. Observation on 12/15 the resident was resticlosed. Both of the haresident was laying of bed. The resident has under the right hip, tu Observation on 12/16 revealed the resident room table waiting for the wireless alarm on Observation on 12/16 resident was sitting in pressure alarm engaged own the hall and was end of the west hall. Observation on 12/16 resident was sitting in watching the birds in watching the birds in situation.	g to lying down and state was suffering from he care plan will be chate heelchair alarm pad on mize risk of delaying the intervention lacked e staff with failure to be plan. The ent quarterly, dated 4/2 and the resider dated on 7/23/14, reveang the resident is a high failure to be plan. The his/her right side in the sa wireless pressure al med on.	arged top lie	F 323				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1` ′	E CONSTRUCTION	(X3) DATE SUR' COMPLETE	
		17E577		B. WING		12/23	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE		
ANDERSON COUNTY HOSPITAL LTCU				APLE ST-PC FT, KS 6603			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	resident's alarm was recliner. Interview on 12/17/2 resident's family me does not remember brought in a lot of no requested placemer cushion of the whee top of the cushion. On 12/17/2014 at 2: stated the pressure and bed and the resident should be a lar cushion on the chair impaired. He/She the independent to push help. The resident is anything for very should be a reminding the resident appropriate intervent on 12/18/2014 at 9: stated when the resident matter how much the off. The alarm was to bottom. The resident matter how much the The resident had no the time. On 12/17/2014 at 2:	s under his/her buttock in 2014 at 1:19 PM, with he mber, revealed the reside to ask for help. He/She on skid socks. He/She on skid socks. He/She on to f the alarm put under lichair, but now it was on 49 PM, direct care staff alarms are to be in any sident was to always haven is to be under the big. The resident is cognitive inks the resident is cognitive in the call light and ask for the call light and ask for the call light was the resident uses it. He/S by where that the staff chalarms. He/She did not the call light was to be right under the chair as pad to make the alarm to be right under the resident uses the call light estaff reminds the resident skid socks that are on 59 PM, licensed nursing	lent has er the dent has er th	F 323			
	N, stated the resider	nt was very independent elf/herself. The resident	and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E577		B. WING		12/2	12/23/2014	
NAME OF PROVIDER OR SUPPLIER			STREET ADDI	RESS, CITY, STA	TE ZIP CODE			
ANDERSON COUNTY HOSPITAL LTCU 421 S MAPLE ST-PO BOX 309 GARNETT, KS 66032								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	TION SHOULD BE COMPLETION DATE		
F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 323					
	interventions for this	cognitively impaired reseen 5/4/14 to 12/1/14 w	ident					